STATE OF IOWA

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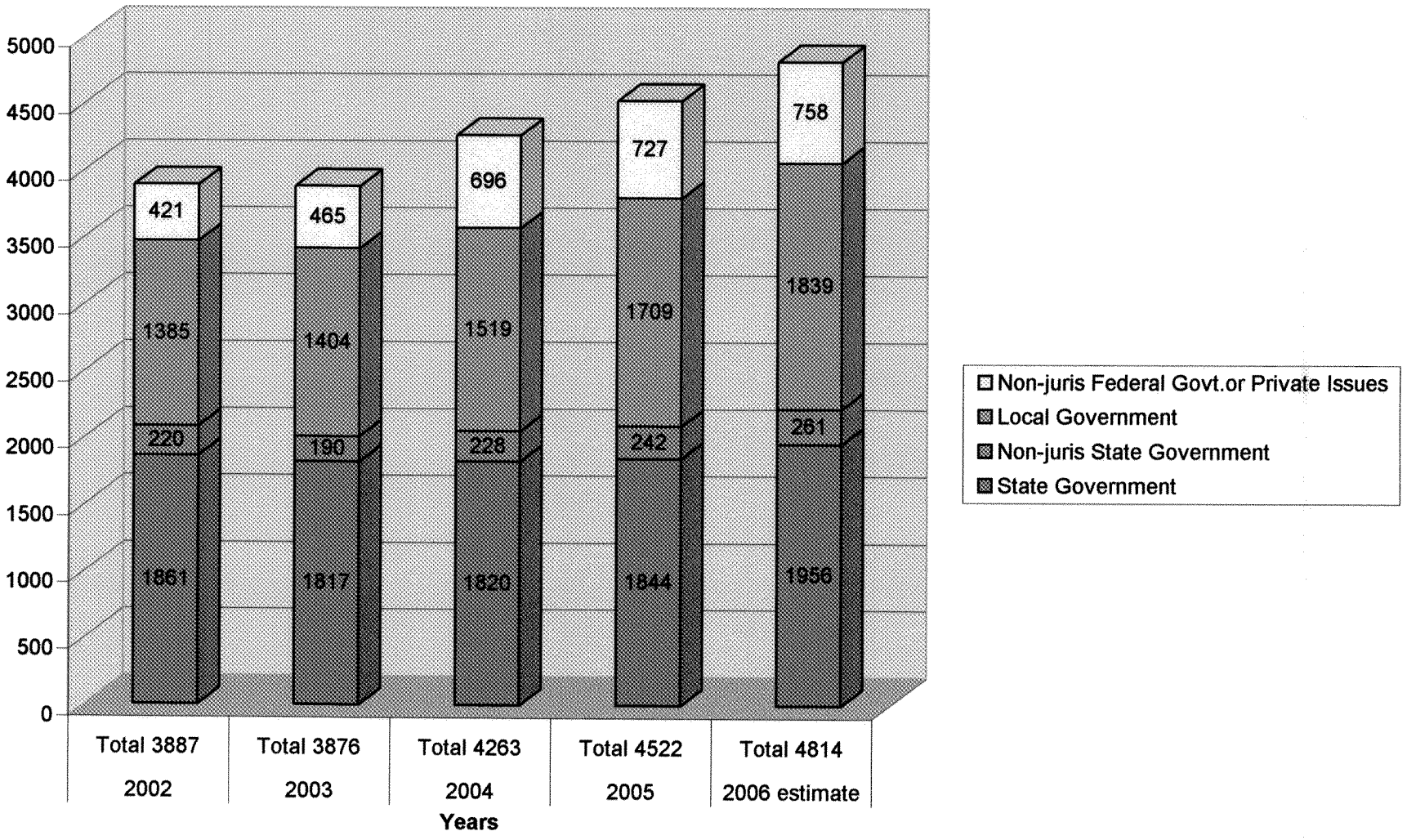
CITIZENS' AIDE/OMBUDSMAN
OLA BABCOCK MILLER BUILDING
1112 EAST GRAND AVENUE
DES MOINES, IOWA 50319

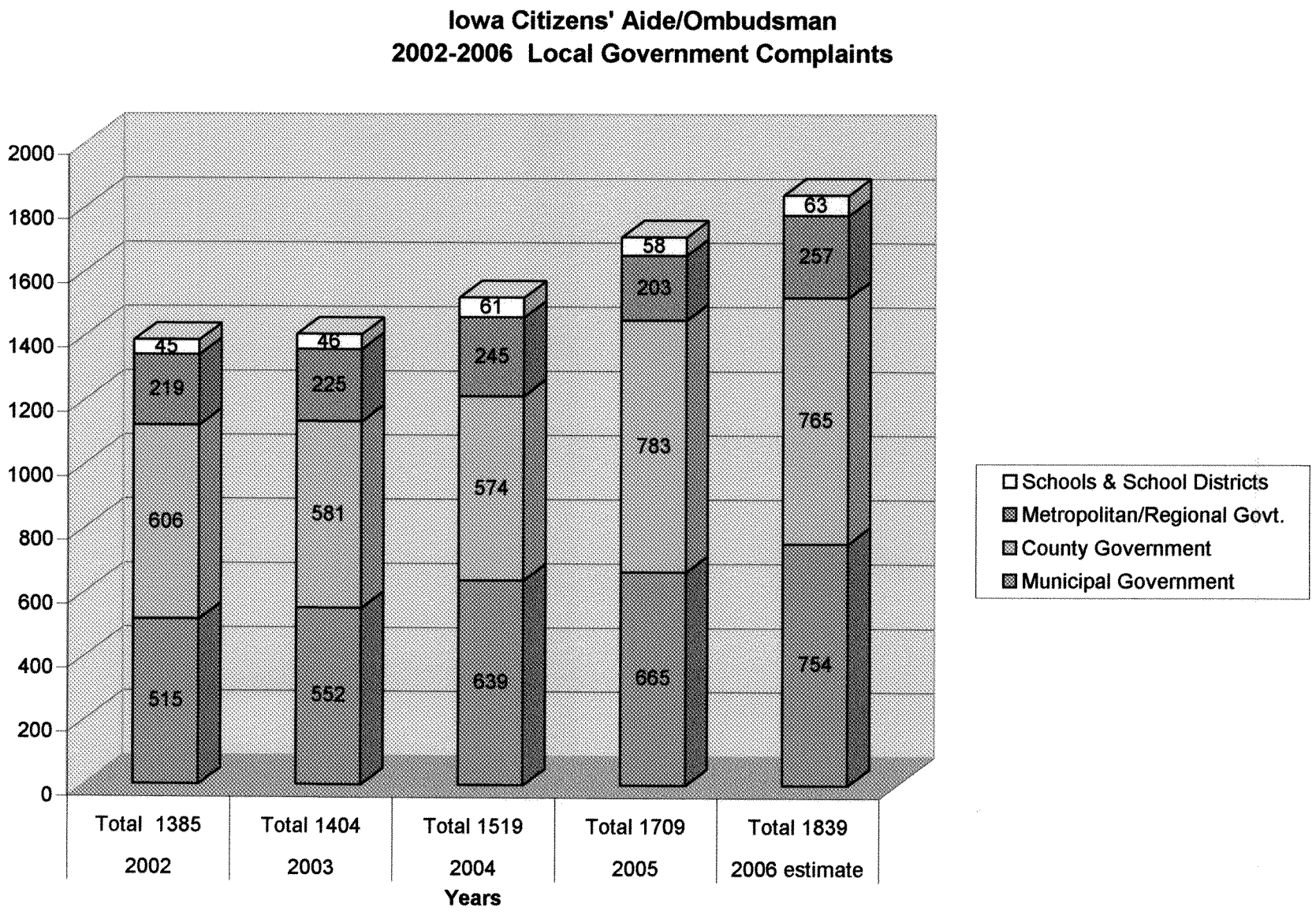
WILLIAM P. ANGRICK II
CITIZENS' AIDE/OMBUDSMAN

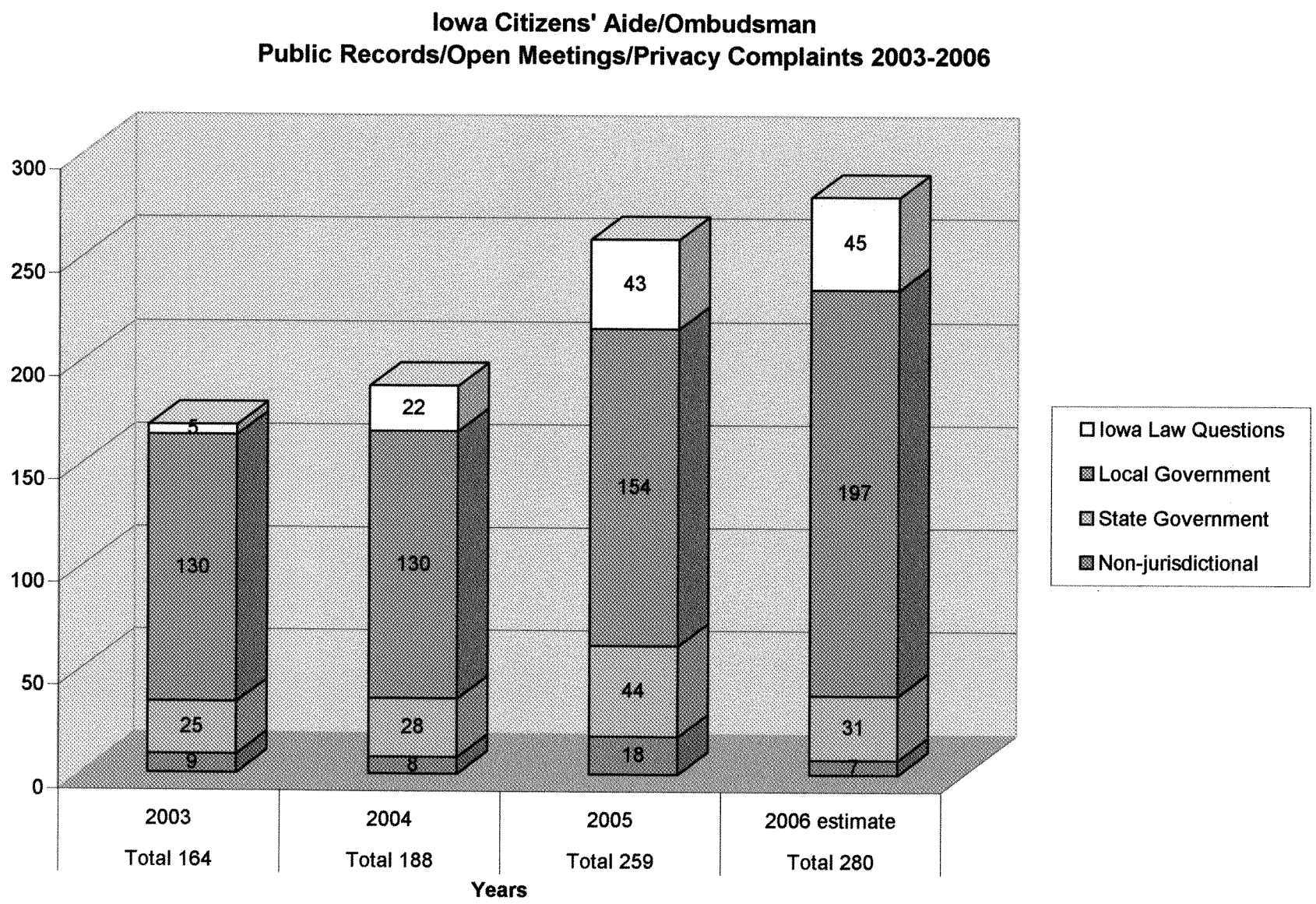
The following information is contained in this packet:

- 2002-2006 Complaints Opened by Agency
- 2002-2006 Local Government Complaints
- 2003-2006 Public Records/Open Meetings/Privacy Complaints
- 2003-2006 Local Government Public Records/Open Meetings/Privacy Complaints
- 2002-2006 County Jails, Corrections & Community Based Corrections Complaints
- 2004-2006 Community Based Corrections, Corrections and County Jail Complaints by Category
- 2002-2006 Department of Human Services Complaints
- Preliminary Data of 2006 Cases Involving Mental Health Issues

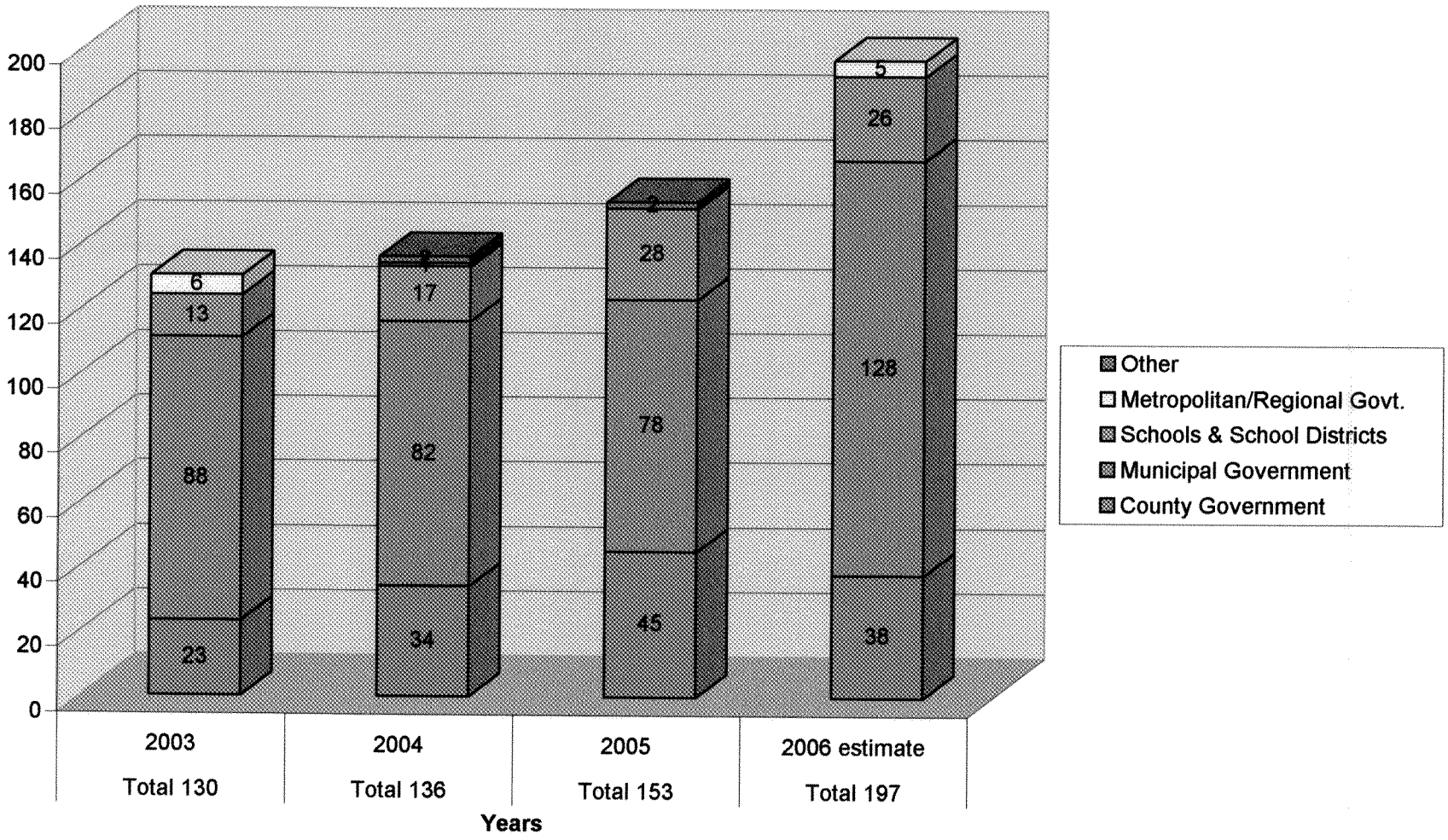
Iowa Citizens' Aide/Ombudsman
2002 - 2006 Complaints Opened By Agency



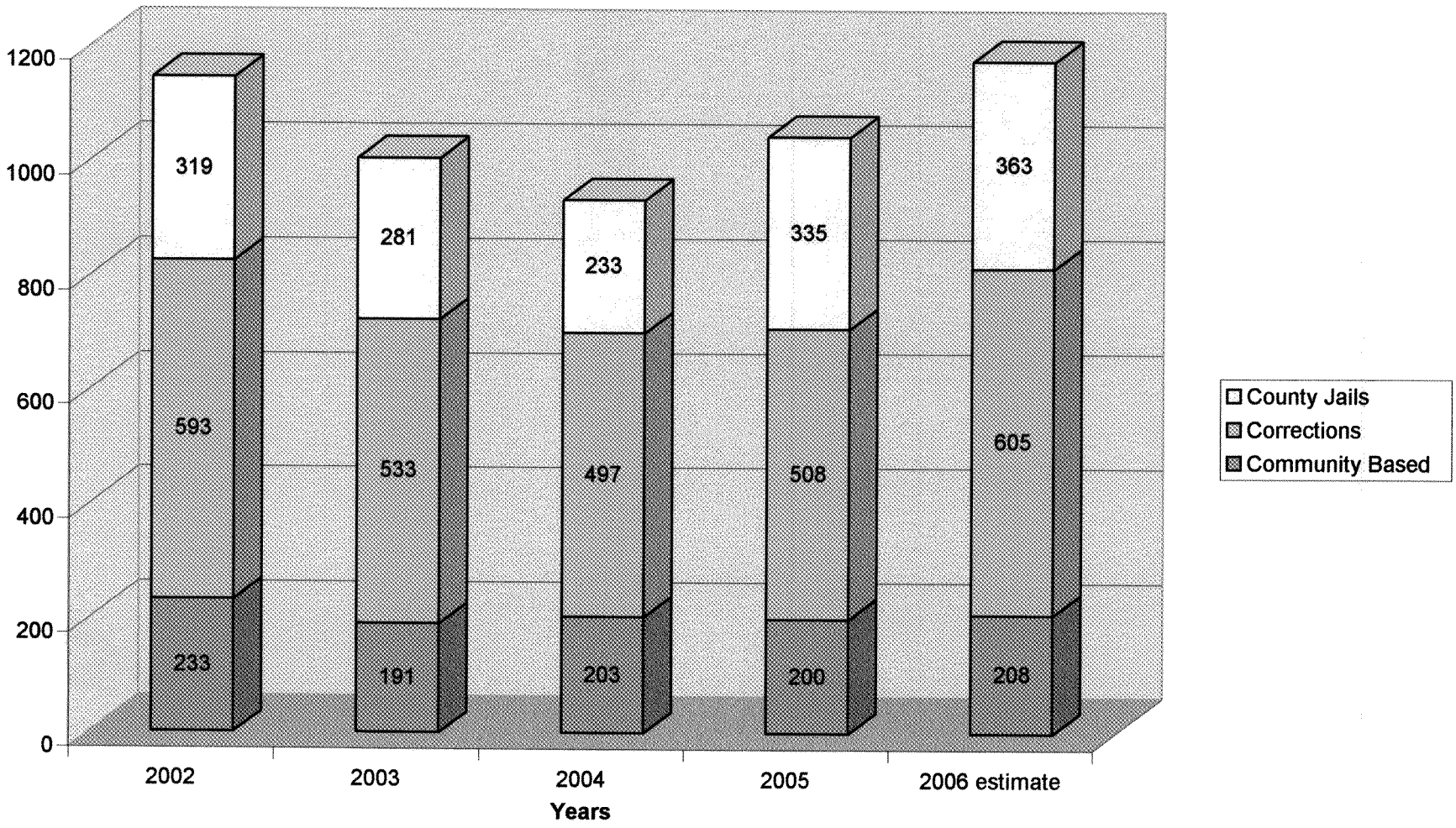

Iowa Citizens' Aide/Ombudsman
2002-2006 Local Government Complaints
2000
1800
1600
1400
1200
1000
800
600
400
200
0
45
219
606
515
46
225
581
552
61
245
574
639
58
203
783
665
63
257
765
754
Total 1385
2002
Total 1404
2003
Total 1519
2004
Total 1709
2005
Total 1839
2006 estimate
Years
Schools & School Districts
Metropolitan/Regional Govt.
County Government
Municipal Government


Iowa Citizens' Aide/Ombudsman
Public Records/Open Meetings/Privacy Complaints 2003-2006
300
250
200
150
100
50
0
5
130
25
9
22
130
28
8
43
154
44
18
45
197
31
7
Iowa Law Questions
Local Government
State Government
Non-jurisdictional
2003
Total 164
2004
Total 188
2005
Total 259
2006 estimate
Total 280
Years

Iowa Citizens' Aide/Ombudsman
Public Record/Open Meetings/Privacy
Local Government Complaints 2003-2006



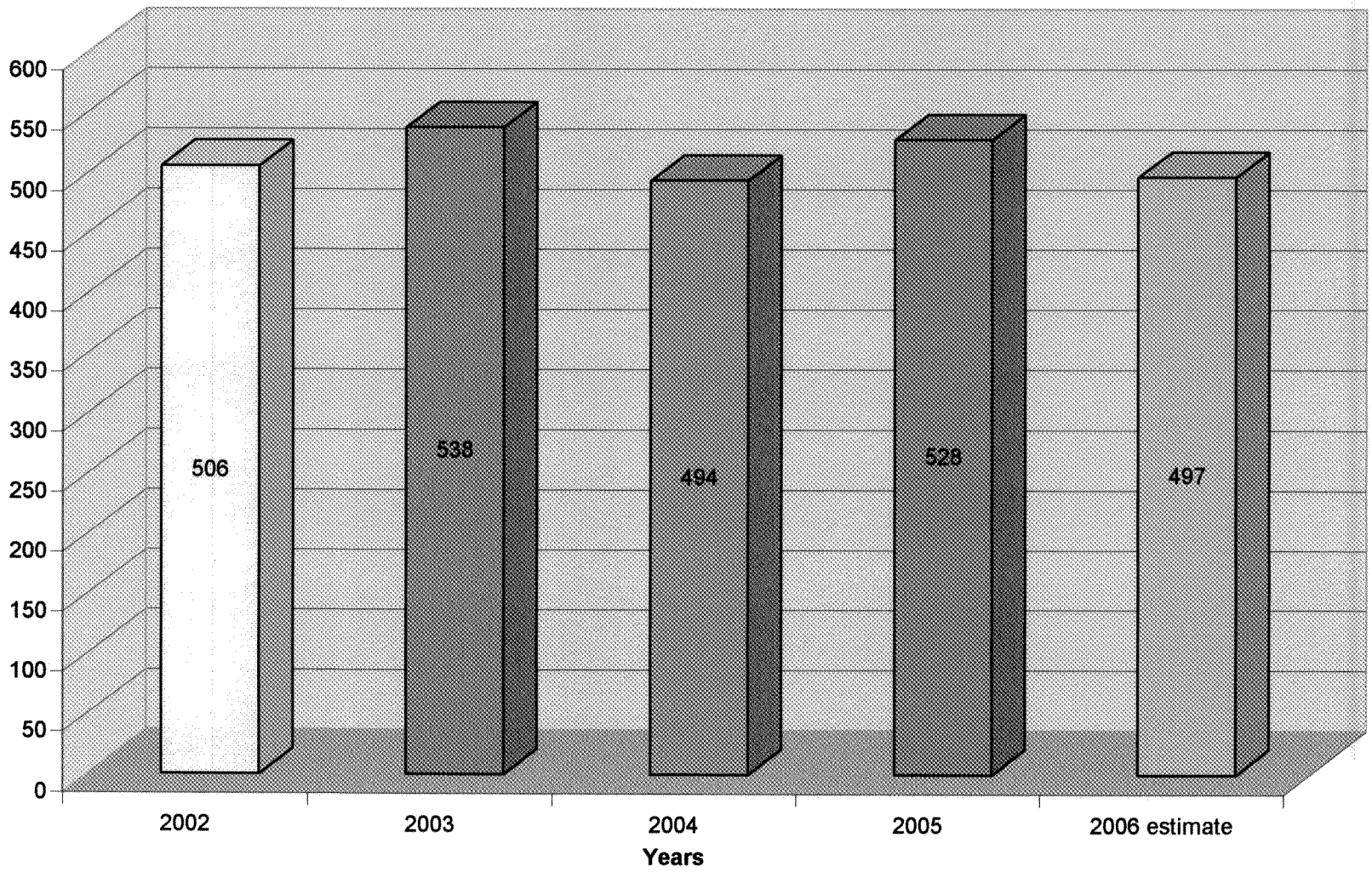
Iowa Citizens' Aide/Ombudsman
County Jails, Corrections & Community Based Corrections Complaints
2002-2006



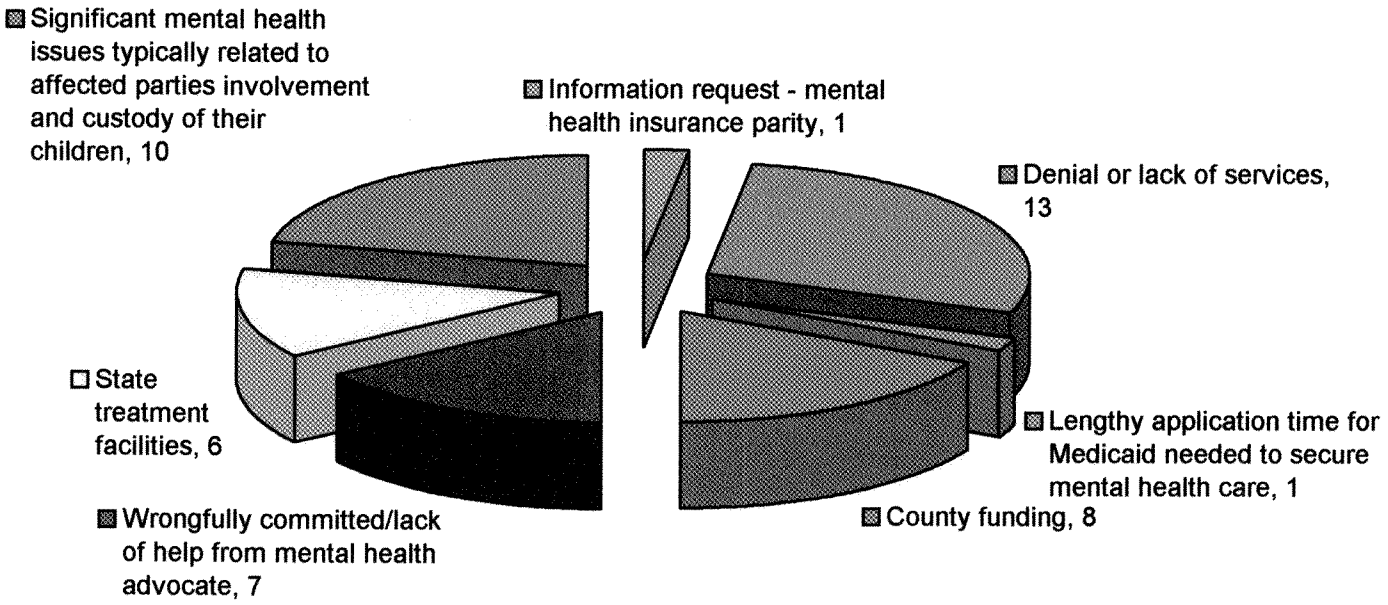
Iowa Citizens' Aide/Ombudsman
Community Based Corrections, Corrections and County Jail Complaints by Category

	2004	2005	2006 estimate		2004	2005	2006 estimate		2004	2005	2006 estimate
	Community Based Corrections				Corrections				County Jails		
Account	12	10	9		26	22	23		12	17	8
Conditions of Confinement	20	13	17		78	62	44		61	119	83
Custody/Classification	17	13	10		57	56	53		9	16	10
Discipline	40	37	27		61	67	85		12	14	17
Grievance	15	3	6		35	25	23		24	20	20
Health Services	8	8	15		90	114	114		85	128	159
Legal Resources	0	1	2		3	6	4		6	13	15
Mail	0	1	0		12	13	19		16	28	24
Property	4	2	2		21	19	27		9	11	9
Release	34	31	31		29	32	34		6	6	3
Religion	3	1	2		8	5	8		3	8	4
Revocation	16	21	19		2	3	1		0	0	0
Rights & Privileges	27	21	36		27	36	33		18	18	25
Conduct	15	21	23		33	49	57		17	26	33
Telpehone	0	0	0		4	8	9		2	9	15
Time Computation	7	3	11		52	38	49		4	7	13
Transfer	5	9	4		37	42	49		3	2	5
Treatment Programs	17	11	11		20	29	42		2	1	1
Use of Force	0	0	1		8	7	8		7	13	22
Visits	4	4	6		41	32	32		4	12	7
Work	12	6	13		10	14	10		1	2	2
Other	21	18	32		26	40	37		7	9	18
Unknown	0	1	3		0	1	2		0	0	1
Total	277	235	280		680	720	763		308	479	494

Iowa Citizens' Aide/Ombudsman
Department of Human Services Complaints 2002-2006



Iowa Citizens' Aide Ombudsman
Preliminary Data of 2006 Cases Involving Mental Health Issues*
(46 cases)



* Does not include complaints on mental health issues pertaining to corrections, county jails or community based corrections.

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WILLIAM P. ANGRICK II
CITIZENS' AIDE/OMBUDSMAN

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OLA BABCOCK MILLER BUILDING
1112 EAST GRAND AVENUE
DES MOINES, IOWA 50319

To: Members of the Iowa General Assembly
From: William P. Angrick II, Ombudsman/Ombudsman
Re: Memorandum on SSB 1087 Concerning Whistleblower Complaints

The purpose of this bill is to provide for the following regarding complaints from state employees to the Citizens' Aide/Ombudsman (Ombudsman) alleging violations of the whistleblower law, section 70A.28:
1) Reasons under which the Ombudsman may decline to investigate a complaint.
2) The persons to whom the Ombudsman shall issue a report of the findings.
3) Prohibition against compelling the Ombudsman to testify regarding the report of findings.

In 2006, the General Assembly enacted section 2C.11A, stating the Ombudsman "shall" investigate complaints from certain state employees alleging violations of section 70A.28. Under section 2C.12, the Ombudsman has discretion to decline investigation of complaints regarding an agency's administrative action. It is uncertain whether this discretion applies to allegations under section 2C.11A. This bill clarifies or provides that this discretion also applies to complaints under section 2C.11A. This would allow the Ombudsman to decline to investigate a complaint which is trivial, frivolous, vexatious, or not made in good faith, or for which the complainant is already pursuing another adequate recourse or remedy.

In addition, while section 2C.11A requires the Ombudsman to issue findings of an investigation, it does not state who receives the findings. This bill provides that the report of findings shall be provided to the employee, the agency head or director, or the Governor if the agency head or director is the subject of the complaint, and the legislative oversight committee.

Furthermore, the 2006 amendment to section 70A.28 allows for the Ombudsman's findings to be introduced as evidence before the public employment relations board (PERB), if the employee appeals an adverse employment action with PERB. It does not address whether the Ombudsman may be required to testify regarding the findings. Under section 2C.20, the Ombudsman is generally immune from being compelled to testify regarding any matter involving the exercise of the Ombudsman's duties. Consistent with section 2C.20, the bill clarifies or provides that the Ombudsman cannot be compelled to testify in a proceeding before PERB.

Memorandum

STATE OF IOWA
IOWA
OMBUDSMAN

TO: William P. Angrick II, Ombudsman
FROM: Judith Milosevich, Assistant for Corrections
RE: Mental Health Issues in Prisons
Date: February 7, 2007

As the number of patients declined in the mental health institutes, the population of offenders with mental illness rose.

The Department of Corrections unit at the Iowa Medical and Classification Center is currently used for offenders and non-offender patients. According to research conducted by the Durrant Group, of the 23 states reviewed so far, Iowa is the only state that houses its forensic psychiatric unit inside a prison. Most states have a dedicated forensic unit on the grounds of a mental health institution and/or have community-based resources who conduct competency evaluations at the jail or in the community.

Iowa Code section 904.201 permits (non-offender) patients to be transferred to the Iowa Medical and Classification Center for forensic evaluation, pre-trial competency evaluation and treatment and other civilian transfers. The result of this is a potentially unsafe mixture of offenders and non-offenders housed together, something not permitted in the county jails by the Iowa Administrative Code (201 IAC 50.13[c]). There are no beds in this unit for female offenders who need psychiatric hospitalization resulting in female offenders being housed next to males in a segregation housing unit, the least healthy environment for those in need of psychiatric intervention.

I question whether this 23 bed unit can meet the needs of offenders in crisis and conduct the competency evaluations for potentially all 99 counties as well as house those found Not Guilty by Reason of Insanity. As of February 7, 2007, the patient program housed 2 convicted offenders, 7 males for competency evaluations and treatment prior to trial, 3 Not Guilty by Reason of Insanity, 3 civil commitments, and there are 16 on a waiting list for competency evaluations and treatment.

Approximately one-third of the male offender population in prison has a mental illness. Approximately 60% of the female offender population has a mental illness.

Some examples of prison mental health staffing issues:

Anamosa, with an offender population of approximately 1300 offenders has one staff psychologist. Approximately 300 of those offenders have a diagnosed mental illness.

Clarinda Correctional Facility has in total numbers the largest population of mentally ill offenders and has two psychologists for a prison population of 938 in medium security. Of the 544 offenders identified as special needs, 400 are on psychiatric medications and they have only 20 clinic slots (or 6.5 hours) per week, meaning each offender gets about 20 minutes with a psychiatrist every few months. Some offenders are not seen for six months or more, due to lack of psychiatric hours.

Mentally ill offenders comprise nearly 60% of the female population. The Iowa correctional Institution for Women (ICIW), with a population of 638 is almost 30% over design capacity. ICIW has two psychologists, but only 8 psychiatric hours per week. This amount psychiatric time does not permit appropriate medication reviews every 30 -180 days depending upon diagnosis and medication (American Correctional Association Standards for Health Care Programs).

Some mental health positions have not been filled in order to pay for the increasing costs of medications and fuel.

According to a publication by the Center for Public Representation, the guidelines often used by the courts are recommended by the National Commission on Correctional Health Care, Standard for Health Services in Prison (1997). The caseload of a prison psychiatrist should be no more than 125-150. Using those figures, Iowa should have 19 psychiatrists for the approximately 3,000 mentally ill offenders. They currently have four full-time psychiatrists.

Anecdotal information from mental health staff reveals they cannot keep up with regular reviews and assessments of offenders newly transferred to their institutions. It is not unusual for offenders to wait two months to see a psychologist after making a request for an appointment.

Some offenders are leaving the institutions (by discharge, work release or parole) with 180 day prescription of their medication even though they may not have been seen by mental health staff in months. Staff says they cannot review all of those with mental illness prior to their release because there are too many. Once an inmate is released to the community, it may take two to three months to get an appointment with a mental health provider. In the meantime, the offender may have a prescription, but no means to pay for refills.

Many of these offenders have co-occurring disorders such as substance abuse and other mental illness diagnoses. There is need not only for more mental health staff, but more treatment programs. As illustrated by a recently released report from The Iowa Consortium for Substance Abuse Research and Evaluation (http://www.idph.state.ia.us/bhpl/common/pdf/substance_abuse/jail_based_cost_analysis.pdf) treatment programs in jail are more cost-effective than those in prisons and are effective in reducing recidivism. I believe we could reasonably assume treatment for co-occurring disorders, such as mental health and substance abuse, in the communities would also reduce recidivism at substantially less cost than providing those same services in prison.

Iowa has provided limited resources for development of community-based continuum of services for the mentally ill. Until we get a continuum of care in our communities for these disorders, we will continue to treat many of these people in our prisons and jails. If prisons are Iowa's de facto mental health facilities, then we need to provide treatment to those incarcerated individuals. Hopefully, Iowa will do better in the future.

CENTER FOR PUBLIC REPRESENTATION

246 Walnut Street Mental Health Protection & Advocacy Project

Newton, MA 02460

617/965-0776

617/964-6560 (TTY)

617/928-0971 (FAX)

February 1, 1999

THE LEGAL RIGHTS OF PRISONERS WITH MENTAL DISORDERS

There are at least 1.8 million people incarcerated in prisons or jails in the United States, and the number continues to increase each year. The incidence of mental disorders among prisoners is substantially higher than it is in the community, with approximately ten percent of prisoners suffering from a major mental illness, defined as schizophrenia, bipolar disorder, or major depression. Indeed, the Los Angeles County Jail has been called the largest *de facto* mental hospital in the world. Additionally, at least 1-2% of all inmates have a developmental disability.

Despite the tremendous demand for mental health treatment, the available services in many, if not most, prisons and jails are woefully inadequate. In the words of Stuart Grassian, a Harvard Medical School psychiatrist who has served as an expert witness in many prison mental health cases, "I've seen people who are horribly ill, eating their own feces, eating parts of their body, howling day and night and it's ignored, like 'who cares?' You think it belongs to some other century, but you go into the prison and you think you're back in some medieval torture chamber. The prison has become this place that's hidden and secret and it's really awful." Given the lack of resources available to treat prisoners with mental illness, it is not surprising that the suicide rate in prisons and jails is much higher than in the community as a whole. Nor is suicide the only risk. Prisoners with untreated mental illness are also vulnerable to victimization by other inmates, may pose a threat of assault to correctional officers and staff, and can seriously disrupt the prison routine. They are also likely to face discrimination in classification, access to rehabilitative programs, and parole.

Constitutional Principles

Since there is little public or political support for quality mental health care for offenders with mental illness, prisoners have been almost entirely dependent on the courts for protection of their right to

treatment. Dozens of class action law suits have successfully attacked the overall quality of care in correctional institutions across the country. *See e.g., Coleman v. Wilson*, 912 F.Supp. 1282 (E.D. Cal. 1995); *Austin v. Pennsylvania Dept. of Corrections*, 876 F. Supp.. 1437 (E.D. Pa. 1995); *Dunn v. Voinovich*, Case No. C1-93-0166 (S.D. Ohio 1995); *Madrid v. Gomez*, 889 F. Supp. 1146, 1280 (N.D. Calif. 1995); *Langley v. Coughlin*, 715 F.Supp. 522 (S.D.N.Y. 1989), *aff'd* 888 F.2d 252 (2d Cir. 1989).

The starting point for an understanding of the constitutional principles underlying the claim of inmates to mental health services is *Estelle v. Gamble*, 429 U.S. 97 (1996), where the Supreme Court held that the Eighth Amendment's prohibition against cruel and unusual punishment endows all inmates with a right to medical care. Specifically, the court ruled that prison officials may not exhibit "deliberate indifference" to the "serious medical needs" of inmates. Thus, an Eighth Amendment claim has two basic elements: an objective component, the existence of a "serious medical need"; and a subjective, or state-of-mind, component, namely that a prison official was "deliberately indifferent" to the need for treatment. The cases elaborating the constitutional requirements in this area, however, are often murky and inconsistent. For example, courts have considerable difficulty in deciding what mental health needs are "serious" enough to mandate treatment. *Compare Steele v. Shah*, 87 F.3d 1266, 1267 (11th Cir. 1996) (prisoner who "suffered from insomnia, anxiety, and various bodily pains" and "feelings of helplessness" stated a claim under the Eighth Amendment) *with Doty v. County of Lassen*, 37 F.3d 540 (9th Cir. 1994) (female prisoner who experienced nausea, shakes, headache, sleeplessness, and depressed appetite suffered merely from "mild, stress-related ailments" and "routine discomfort" did not have a "serious" medical need). Generally, however, prisoners have a right to psychological or psychiatric treatment under the Eighth Amendment if a physician or other health care provider "concludes with reasonable medical certainty (1) that the prisoner's symptoms evidence a serious disease or injury; (2) that such disease or injury is curable or may be substantially alleviated; and (3) that the potential for harm to the prisoner by reason of delay or the denial of care would be substantial." *Bowring v. Godwin*, 551 F.2d 44 (4th Cir. 1977). Thus, mild depression and anxiety associated with the stress of the prison experience will not be regarded as a "serious," while any condition that is diagnosed by a doctor as mandating treatment must receive professional attention.

Discerning whether or not prison officials have demonstrated the requisite "deliberate indifference" can be similarly confusing. It is not enough that prison officials exercised poor judgment, or that they were negligent or even grossly negligent; rather the inmate must show that the prison official was at least reckless, and reckless in the criminal sense, meaning that he or she had actual knowledge of a condition that required treatment. *Farmer v. Brennan*, 511 U.S. 825, 828-829 (1994). This does not mean that prison officials may shield themselves from liability by deliberately remaining ignorant about the need for treatment. They will still be held accountable if they deliberately disregard a known risk, even if they are ignorant of the details of a particular inmate's situation.

Basic Components of a Prison Mental Health System

While there may be controversy about whether a specific inmate has received constitutionally acceptable care, the courts have established a clear set of minimum requirements for an adequate system of prison mental health care. Further, a number of professional organizations, such as the National Commission on Correctional Health Care and the American Psychiatric Association, have promulgated standards governing mental health services in prisons and jails. *See e.g.,* National Comm'n on Correctional Health Care, *Standards for Health Services in Prisons* (1997). Although courts are fond of saying that the professional standards may well exceed the constitutional floor, they

often utilize such standards, both to evaluate the quality of mental health care and to devise remedies for conditions found to be unlawful.

The essential components of a prison mental health system are set forth below. For a more detailed account, including citations to professional standards and cases, consult the Summary of Professional Standards Governing Mental Health Services in Prisons and Jails published by ATTAC in 1998.

1. *Screening and Evaluations*

The first requirement is that every inmate be screened upon admission in order to identify those with mental illness or developmental disabilities. This generally entails a standardized set of questions and observations by specially trained staff. The screenings must be conducted in a confidential setting. There must be a mechanism to ensure that all inmates identified as possibly suffering from a mental disorder are promptly referred for a comprehensive mental health evaluation and any necessary treatment. The threshold for referral for services must be low, both upon admission and later, since it is easy for mentally ill inmates to escape notice in the prison environment so long as they do not engage in egregiously bizarre behavior. In addition, inmates must be monitored throughout their incarceration in the event they develop signs and symptoms of mental illness. It is crucial that inmates who are in segregation or solitary confinement be assessed by mental health staff at least once per week. It is also vital that the institution have a program to identify and supervise suicidal inmates and those in crisis.

2. *Treatment Modalities*

Correctional institutions must provide a range of meaningful treatment modalities to inmates identified as having a mental disorder. Although many prisons and jails simply confine mentally ill inmates to segregation units where they can be closely supervised, this is not acceptable. The institution must make available psychotropic medication if needed. Psychotropic medication must be prescribed only by a psychiatrist and in accordance with contemporary medical standards. Psychiatrists or physicians should monitor all inmates on psychotropic medications and re-evaluate the patient before renewing the prescription. Further, the prison formulary should contain a range of psychotropic medications.

Medication alone, however, is not sufficient. It must be part of an overall program of therapy, including individual and group therapy where appropriate, as well as crisis intervention services. Each inmate with a chronic mental disorder should also have an individualized treatment plan. In addition, the facility must provide qualified interpreters to ensure that non-English speaking inmates have access to mental health services. Further, no inmate with a history of mental illness should be disciplined without first consulting with mental health staff.

3. *Qualified Mental Health Staff*

It is absolutely essential that the institution have sufficient numbers of qualified and trained staff to provide treatment consistent with contemporary standards of care. This means the facility must have an adequate number of psychiatrists, psychologists, and other mental health professionals, either on site or on call, to provide all necessary services. Although there are no clear standards quantifying an appropriate number of mental health professionals, experts generally insist that the caseload of a

prison psychiatrist should be no more than 125-150, and jail psychiatrists should not have a caseload that exceeds 75-100. One of the worst consequences of inadequate staffing is that only those mentally ill prisoners who exhibit especially bizarre behavior, or who are assaultive and disruptive, are likely to receive any treatment at all. Even though their illness may be equally severe, those who suffer quietly go unnoticed and unserved. This problem is exacerbated by the common failure to provide sufficient training to correctional officers concerning the signs and symptoms of mental illness.

4. *Special Needs Units and Inpatient Hospitalization*

Like individuals suffering from mental illness in the community, inmates may sometimes need special housing separate from the general prison population to receive more intensive treatment and supervision. This may range from a day treatment program within the prison, to a crisis unit for acutely psychotic or suicidal inmates who does not require inpatient hospitalization, to an intermediate level residential treatment unit for those whose level of functioning makes them vulnerable to abuse from other inmates, are too disruptive for placement in the general population, or who need substantial therapeutic services. Since sometimes nothing short of intensive inpatient hospitalization is adequate for an inmate who has decompensated, the institution must also have a procedure to transfer acutely mentally ill prisoners to a hospital setting.

5. *Accurate Mental Health Records*

Mental health treatment records must be accurate, complete, up-to-date, and well-organized. The facility should also obtain past psychiatric records whenever possible. The inmate's mental health records must be kept confidential by maintaining them

separately from other records. When an inmate is transferred to another institution, his records must be sent to the receiving facility to insure continuity of care.

6. *Discharge Planning*

Since most mentally ill inmates are eventually released back to their communities, it is vital that the facility make an effort to ensure continuity of care after release. This may mean providing the inmate with a medication prescription, as well as arranging for follow-up services in community mental health centers.

7. *Quality Assurance Program*

The institution must have a quality assurance plan to assure that inmates receive competent care. This should include studies of utilization patterns and clinical outcomes in the facility as a whole, as well as analysis of the clinical record of individual prisoners.

Although many prisons and jails have carefully drafted policies and procedures designed to meet their constitutional obligations regarding mental health care, there is often a wide gulf between what exists on paper and the services that are actually available. The quality of the services and the physical plant is also often substandard. Thus, there is no substitute for thorough factual investigation in order to make an assessment of the adequacy of the mental health services in any jail or prison.

Fields of Opportunities

STATE OF IOWA

THOMAS J. VILSACK, GOVERNOR
SALLY J. PEDERSON, LT. GOVERNOR

DEPARTMENT OF CORRECTIONS
GARY D. MAYNARD, DIRECTOR

Iowa Department of Corrections

Report to the Board of Corrections

Mental Health

Second in a series of reports highlighting issues contributing to corrections population growth

April 2006

Introduction

In 1999, the U.S. Bureau of Justice Statistics estimated about 16.3% of state prison inmates, and 16.0% of probationers, were mentally ill, based on offenders' self-reports.[1] In 2000, the American Psychiatric Association reported research estimates that perhaps as many as one in five prisoners were seriously mentally ill.[2] The figures for Iowa inmates cited in this report are higher still, with about one-third of offenders identified as mentally ill.

Deinstitutionalization of the mentally ill from mental health facilities beginning in the late 1950's and early 1960's – and absent the full realization of the community mental health centers that were supposed to take their place – has contributed to institutionalization of the mentally ill in local jails and state prisons.[3]

According to the Iowa Department of Human Services, the average daily population of the four state mental health institutions in Iowa during FY2005 was 236. The largest of these, in Independence, houses about 90 persons on an average day. In contrast, the Iowa prison system on June 30, 2005 held 2,902 mentally ill offenders, and operates the largest functioning mental health facility in the state: the Clinical Care Unit at the Iowa State Penitentiary, which housed 143 offenders on that day.

Psychiatric diagnoses are not readily available for all offenders under community based supervision. This report does document mentally ill offenders returning to the community via parole supervision, as one way of demonstrating the need for community mental health interventions.

This report goes beyond mere documentation of the problem. It describes how the Iowa Department of Corrections is addressing mental health issues among the offender population through the provision of treatment. All data was obtained from Iowa Corrections Offender Network (ICON) information residing in the Iowa Justice Data Warehouse, and the ICON-Medical module.

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[1] Bureau of Justice Statistics, *Mental Health and Treatment of Inmates and Probationers* (U.S. Department of Justice, 1999), 1.

[2] American Psychiatric Association, *Psychiatric Services in Jails and Prisons, 2nd Ed.* (Washington D.C., American Psychiatric Association, 2000), p. XIX, as quoted by Human Rights Watch, http://www.hrw.org/reports/2003/usa1003/3.htm#_ftn13.

[3] Various sources. See, for example, Daniel Patrick Moynihan, *Deinstitutionlization of the mentally ill* (Congressional Record – Senate, July 12, 1999) at http://www.psychlaws.org/GeneralResources/article22.htm. Also H. Richard Lamb, M.D. and Leona L. Bachrach, Ph.D., *Some Perspectives on Deinstitutionalization* (Psychiatric Services, August 2001, American Psychiatric Association) at http://psychservices.psychiatryonline.org/cgi/content/full/52/8/1039.

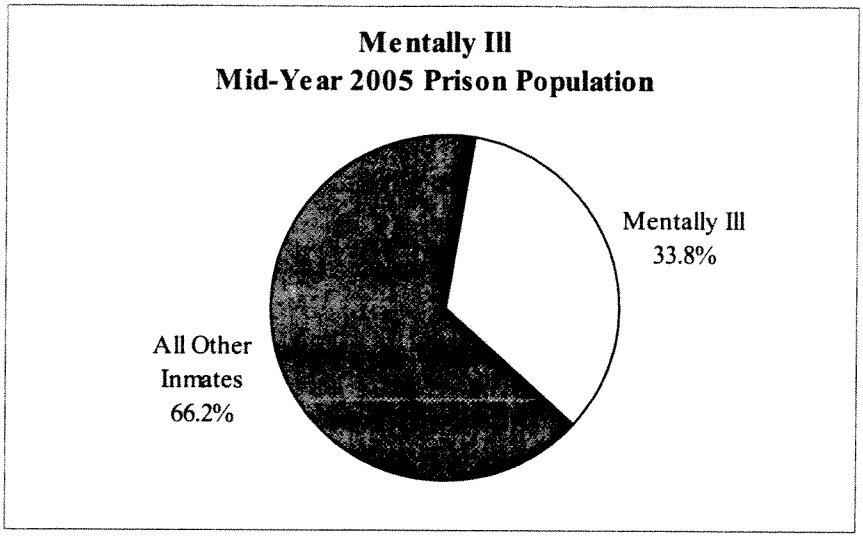
Table of Contents

Lettie Prell, Director of Research, wrote this report under the direction and consultation of Dr. Bruce Sieleni, Director of Mental Health. Statistics and charts were compiled by Sondra Holck, Management Analyst and Ms. Prell. Special thanks to Scott Musel, Paul Stageberg, Laura Roeder-Grubb and Geneva Adkins with the Division of Criminal & Juvenile Justice Planning, Iowa Department of Human Rights, for providing a number of offender data sets and analyses.

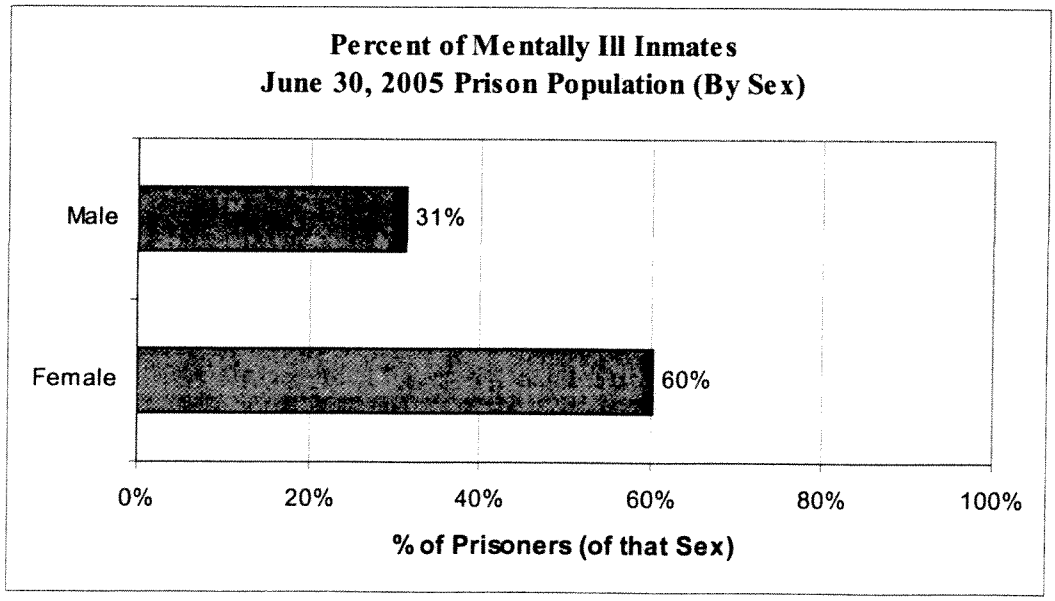
Mentally Ill Offenders in Prison

Prevalence

On June 30, 2005 Iowa's prisons held 8,578 offenders. Of these, 2,902 were mentally ill per psychiatric diagnosis.



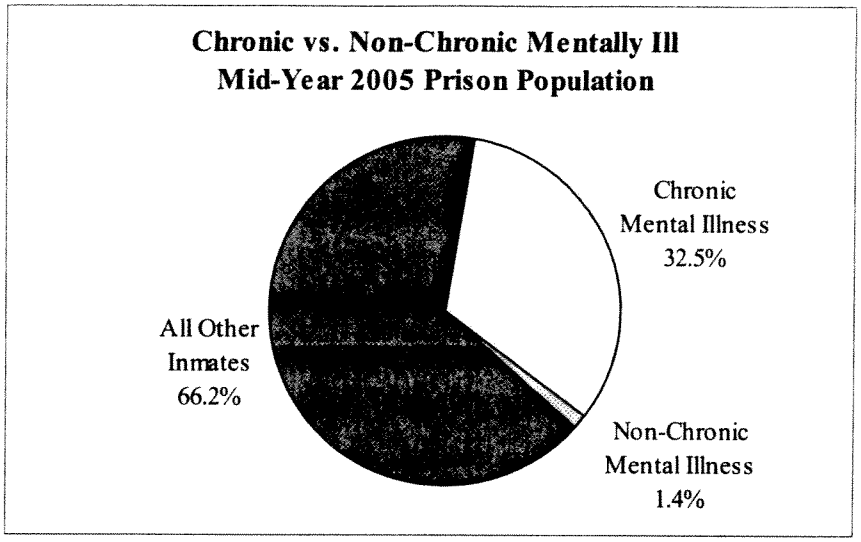
Just under one-third of male offenders, but 60% of female offenders, were diagnosed as mentally ill.



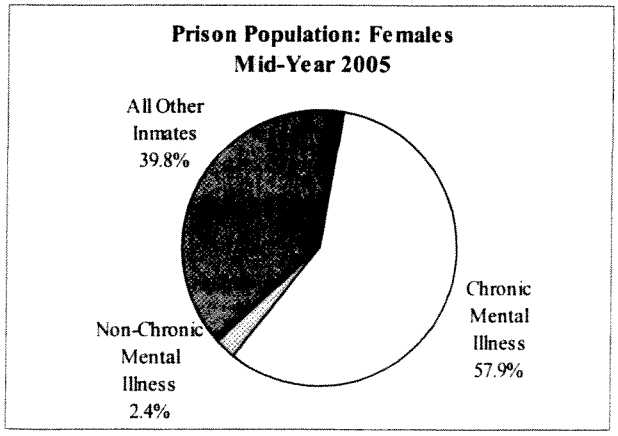
Mentally Ill Offenders in Prison

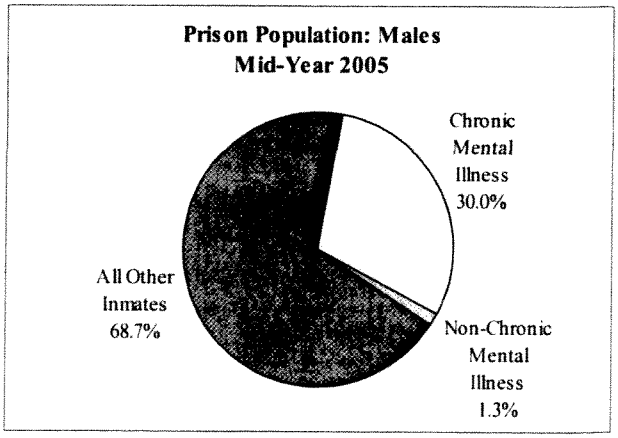
Chronic vs. Non-Chronic Conditions

Some conditions, such as depression and bipolar disorders, are chronic. That is, while the condition may not be presenting a current problem requiring psychiatric care, it cannot be cured, only managed. On June 30, 2005 there were 2,785 offenders with chronic mental illness, and 117 offenders with non-chronic mental illnesses.



There is a higher percentage of both chronic and non-chronic mental illnesses among the female offender population, compared to the male offender population.

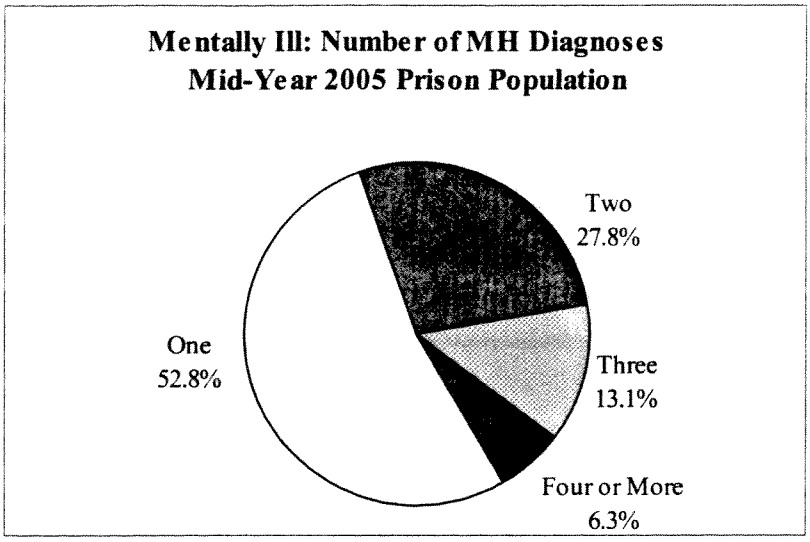




Mentally Ill Offenders in Prison

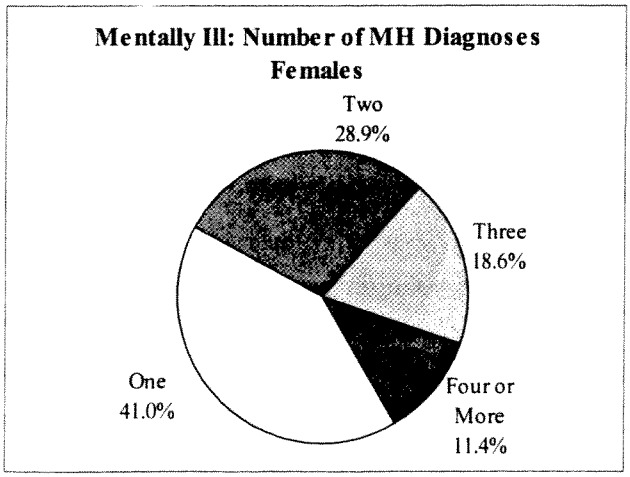
Number of Diagnoses

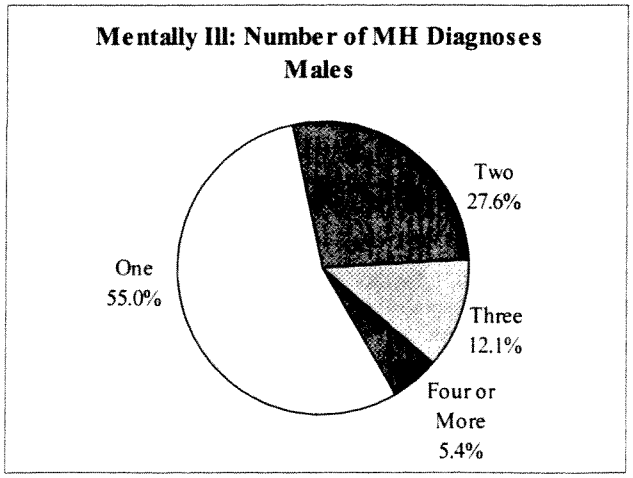
Co-occurring disorders, such as a substance use disorder combined with another diagnosis, is common among mentally ill offenders in prison. On June 30, 2005, there were 1,532 offenders with a single diagnosis of a mental illness, and 1,370 offenders with two or more mental illness diagnoses.



Includes mental illness diagnoses only.

A higher percentage of female offenders have more than one mental health diagnosis, compared to male offenders.





Includes mental illness diagnoses only.

Mentally Ill Offenders in Prison

Diagnoses by Category

Among all offenders in prison on June 30, 2005, depression, substance use disorders, and anxiety/panic disorders were the three most common categories of diagnoses. Prevalence of these among female inmates was higher when compared to males.

Female Inmates: Mental Illness Diagnoses by Category

Mental Illness Category	N Offenders	% of MI	% of Pop
Depression & major depressive disorders	271	59.4%	35.8%
Substance use disorders	135	29.6%	17.8%
Anxiety, general anxiety & panic disorders	123	27.0%	16.2%
Personality disorders	99	21.7%	13.1%
Bipolar disorders	68	14.9%	9.0%
Dysthymia/Neurotic depression	56	12.3%	7.4%
Psychosis/Psychotic disorders	40	8.8%	5.3%
Schizophrenia	25	5.5%	3.3%
Posttraumatic stress disorder (PTSD)	22	4.8%	2.9%
Other adjustment disorders (not PTSD)	15	3.3%	2.0%
Sleep, movement & eating disorders	13	2.9%	1.7%
Impulse control disorders	3	0.7%	0.4%
Dementia	3	0.7%	0.4%
Civil commitment	2	0.4%	0.3%

Male Inmates: Mental Illness Diagnoses by Category

Mental Illness Category	N Offenders	% of MI	% of Pop
Depression & major depressive disorders	1,214	48.7%	15.5%
Anxiety, general anxiety & panic disorders	632	25.4%	8.1%
Substance use disorders	543	21.8%	6.9%
Personality disorders	460	18.5%	5.9%
Dysthymia/Neurotic depression	245	9.8%	3.1%
Bipolar disorders	243	9.8%	3.1%
Schizophrenia	179	7.2%	2.3%
Psychosis/Psychotic disorders	147	5.9%	1.9%
Other adjustment disorders (not PTSD)	79	3.2%	1.0%
Impulse control disorders	46	1.8%	0.6%
Sleep, movement & eating disorders	43	1.7%	0.5%
Posttraumatic stress disorder (PTSD)	36	1.4%	0.5%
Civil commitment	34	1.4%	0.4%
Dementia	11	0.4%	0.1%
Sexual disorders/paraphelias	10	0.4%	0.1%

A given offender is counted only once per category, but may be counted in more than one category.
Data is for the June 30, 2005 prison population.

Mentally Ill Offenders in Prison

Location

Just as persons with mental illnesses are able to function well within general society if given proper community care, the majority of mentally ill offenders are appropriately managed within the general inmate population.

The Clinical Care Unit at the Iowa State Penitentiary is a 200-bed housing unit that has developed strong mental health support capabilities, and many of the most severe cases are housed there (about one-third of this population is schizophrenic, and this is the most common diagnosis category among those residing in the Unit). The most severe mentally ill female offenders are housed at the Iowa Medical and Classification Center.

A 100-bed unit for women at the Mount Pleasant Correctional Facility houses mentally ill offenders as well as those who are behaviorally challenged, such as persons with profound developmental disabilities. Likewise, the 23-bed East Unit at the Iowa Medical and Classification Center, and the 178-bed "special needs" unit to be opened in FY2007 or FY2008 houses a mix of mentally ill and behaviorally challenged offenders. The 23-bed West Unit also houses psychiatric cases; however, over time there has been an increase in the number of patients from The Iowa Department of Human Services Mental Health Institutions and county pretrial mental health evaluations in these beds.

Assessment of the adequacy of these and other resources for offenders who are mentally ill is a priority for the newly appointed Mental Health Director.

Mentally Ill by Facility: June 30, 2005

Facility	N Inmates	Total Pop	% of Pop
Anamosa State Penitentiary	393	1,315	29.9%
Clarinda Correctional Facility	362	954	37.9%
Fort Dodge Correctional Facility	363	1,229	29.5%
Iowa Correctional Institution for Women	340	600	56.7%
Iowa Medical & Classification Center	230	779	29.5%
Iowa State Penitentiary	236	847	27.9%
ISP-Clinical Care Unit	128	143	89.5%
Mount Pleasant Correctional Facility	374	1,035	36.1%
Newton Correctional Facility	380	1,182	32.1%
North Central Correctional Facility	96	494	19.4%
Total	**2,902**	**8,578**	**33.8%**

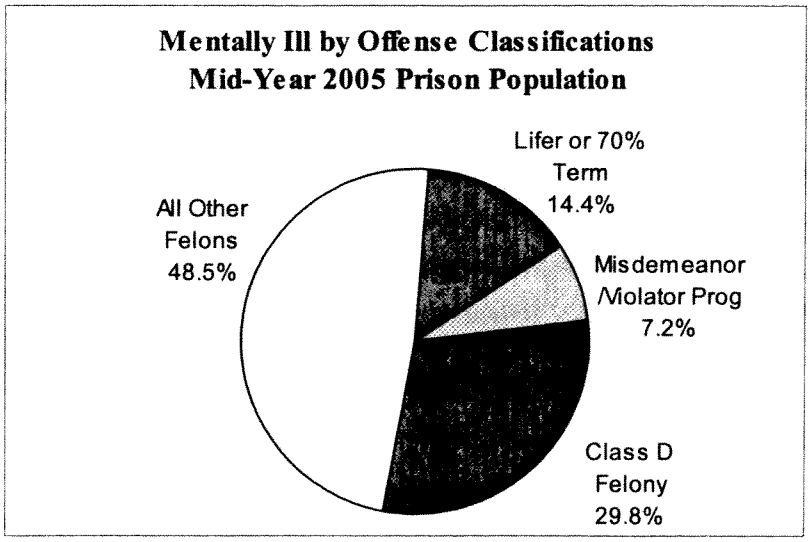
With the exception of the Clinical Care Unit, facility counts include any associated satellites. For example, the Iowa State Penitentiary counts include the John Bennett Correctional Center and the prison farms; the Newton Correctional Facility includes the Correctional Release Center; and so forth.

Mentally Ill Offenders in Prison

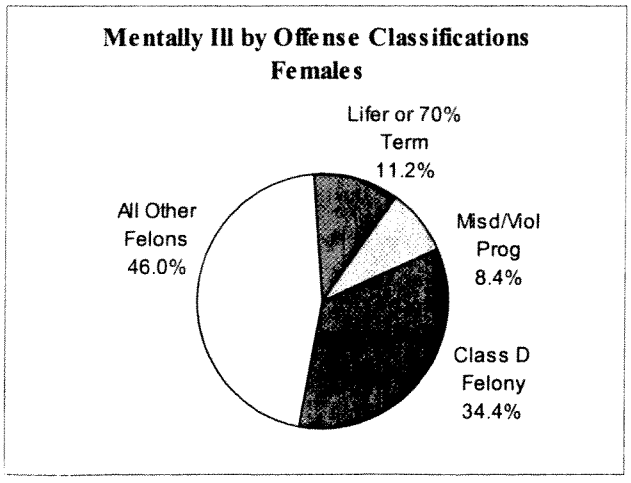
Short-Term vs. Long-Term Prison Inmates

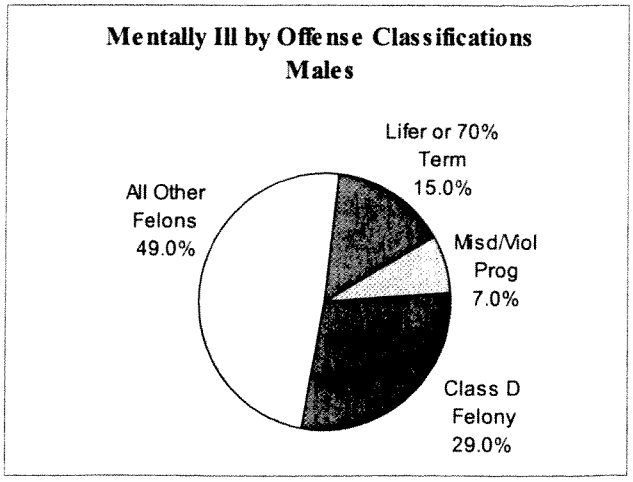
Review of mentally ill inmates by most serious offense reveals implications for offender reentry. The Misdemeanor/Violator Program and Class D Felony groups generally describe inmates with shorter lengths of stay. On June 30, 2005, there were 1,053 inmates with these short-term sentences. Another 1,378 inmates, the All Other Felons group, have generally longer expected lengths of stay in prison prior to reentry.

There are also offenders requiring long-term management of their mental illnesses in a prison setting. The Lifer/70% term group represents inmates expected to remain in prison the longest, potentially for the remainder of their lives (many 70% term offenders are expected to die in prison prior to becoming eligible for parole). On June 30, 2005 there were 410 inmates with these long sentences.



Federal, compact, safekeepers are excluded.

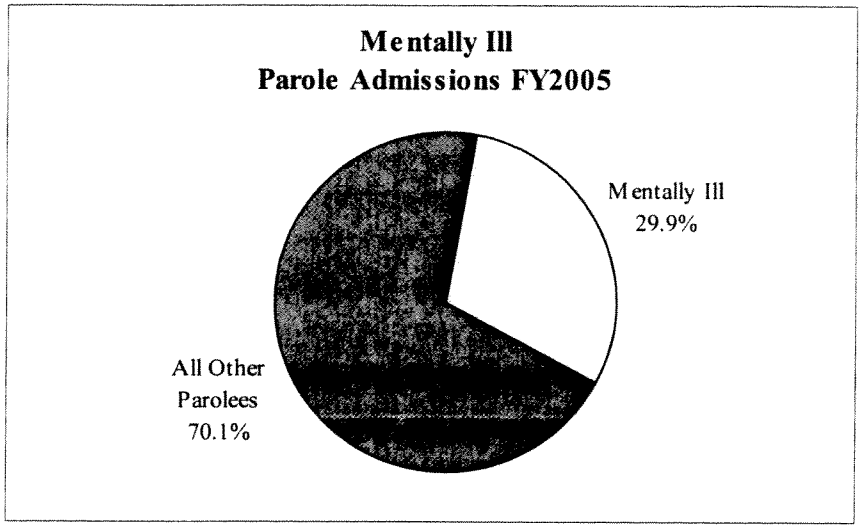




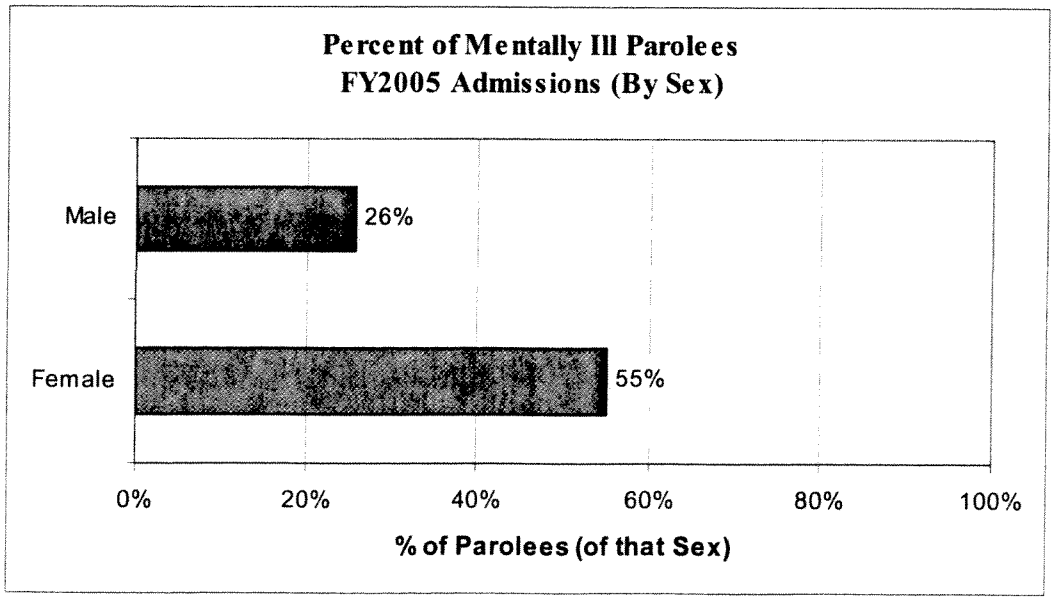
Reentry: Parole Admissions

Prevalence

During FY2005, 2,923 parolees were admitted to field supervision, either directly from prison or following a stay in a community-based work release or OWI treatment facility. Of these, 873 were mentally ill per psychiatric diagnosis.



About 26% of male offenders, but 55% of female offenders, were diagnosed as mentally ill.



Reentry: Parole Admissions

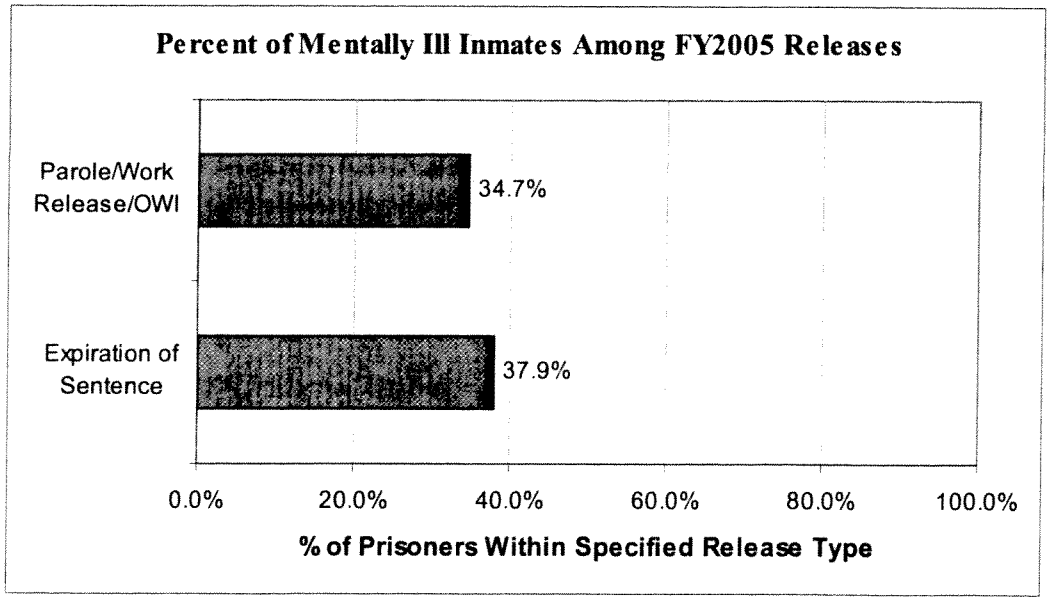
Location

Reentry of mentally ill offenders into the community is a statewide issue, with between 22.5% and 36.0% of district department of correctional services parole admissions involving persons with major mental health issues.

Parole Admissions FY2005			
Region	N MI	Total Admits	MI as % of Admits
1JD	136	442	30.8%
2JD	91	311	29.3%
3JD	71	215	33.0%
4JD	27	120	22.5%
5JD	272	911	29.9%
6JD	71	265	26.8%
7JD	94	351	26.8%
8JD	111	308	36.0%
Total Admissions	**873**	**2,923**	**29.9%**

Reentry: Release from Prison to Supervision vs. No Supervision

A slightly higher percent of offenders who expire their sentences in prison and receive no post-release supervision are mentally ill, compared with those receiving parole, or placement in community-based work release or OWI treatment facilities. However, this difference is not statistically significant, according to an analysis by the Division of Criminal and Juvenile Justice Planning.



Effective Identification & Treatment of the Mentally Ill

Four inmate suicides at the Critical Care Unit (CCU), Iowa State Penitentiary, between January 1, 2003 and November 1, 2004 brought to the fore the need to improve delivery of mental health services within Iowa's prison system. Dr. Thomas White, a consultant provided by the National Institute of Corrections, reviewed the incidents at the CCU as well as mental health services throughout the prison system. Dr. White's report contained many recommendations for change, which the Iowa Department of Corrections has worked to implement.[4] Examples of areas improved include:

- Suicide prevention procedures.
- Mental Health Training for all staff.
- A Mental Health Director to provide overall statewide oversight of DOC Mental Health Programs.
- A clear mission statement and a more therapeutic environment for the CCU.
- Intake and release process to ensure continuity of care and appropriate placement.
- Increased out of cell time to include work, and expanded recreation, hobby craft and education activities for offenders in the CCU.
- Physical changes to the CCU.

There is a tendency for mentally ill offenders to be isolated in prison settings, which is not the best environment, particularly for persons who are depressed. The overall goal of the newly appointed Director of Mental Health for the Iowa Department of Corrections is to parallel community standards in terms of a graduated mental health program. Such a program would contain the following elements:

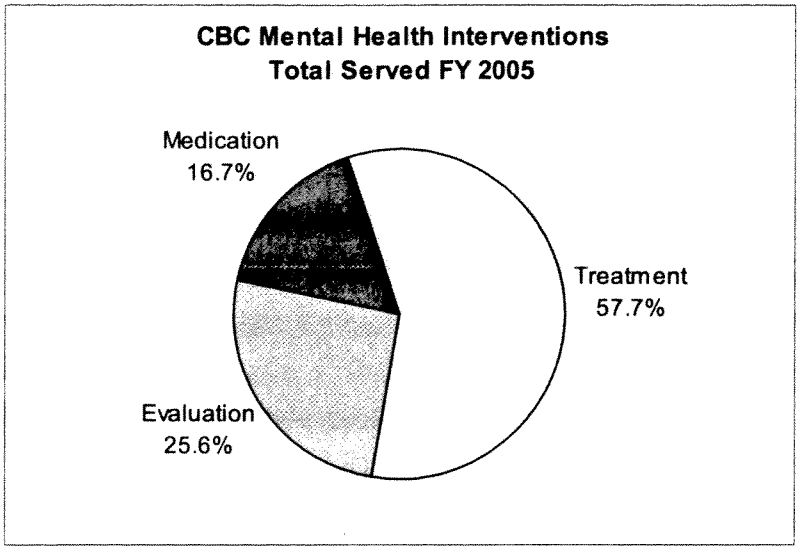
- Continuity of care.
- A continuum of care, with criteria for where a particular offender should be placed based on clinical assessment.
- A formalized acute unit as part of the continuum.
- Programming appropriate to each level of the continuum.

[4] Dr. White's complete report may be found on the Iowa Department of Corrections website at http://www.doc.state.ia.us/publications.asp (see *Mental Health Consultant Report by Dr. Thomas White*).

Mental Health Interventions

Community-Based Corrections

As used in this report, "total served" refers to offenders in the intervention at the beginning of the year, plus new admissions into the intervention. During FY2005, a total of 2,655 offenders under community-based corrections supervision received a mental health intervention (this is "total served"). **Please note these are primarily higher risk offenders; by policy, low risk offenders are not assessed for needs or assigned to interventions. It is also likely for some offenders to see their own psychiatrists/psychologists, and therefore not have a documented intervention on ICON for mental health treatment.**



The majority of mental health treatment is psychiatric or psychological services. However, in recent years, comprehensive programs have been developed that address mental health needs as one component. These include the first judicial district's day program and reentry court program, and the fifth judicial district's Going Home: KEYS Reentry Program. Not represented in the above counts are offenders in the third judicial district's mental health court, because this program is a diversion for lower level misdemeanants. The mental health court focuses on the needs of the mentally ill in an intensive & collaborative manner, by means of suspended disposition or at least jail time with the agreement the individual will participate in community programming.

In addition to mental health interventions, dual diagnosis interventions are available in five out of the eight judicial districts. The largest of these, and the first to get started, is the Waterloo Dual Diagnosis Program, which received the "Exemplary Offender Program" award from the American Correctional Association in 2004. During FY2005, a total of 252 offenders were served in dual diagnosis interventions statewide.

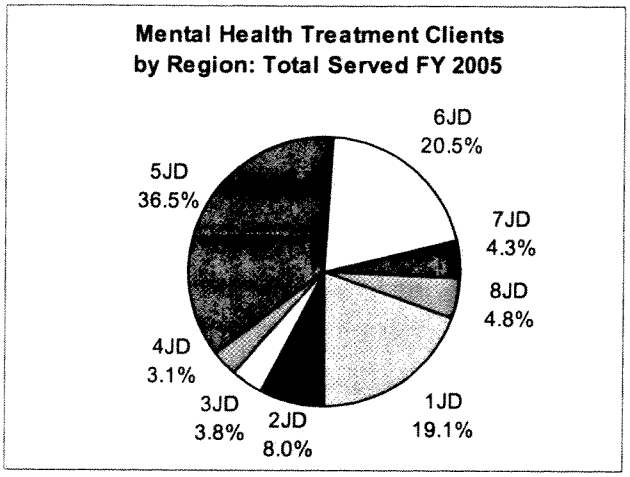
The following pages describe the types of offenders served by mental health treatment and dual diagnosis interventions in FY2005.

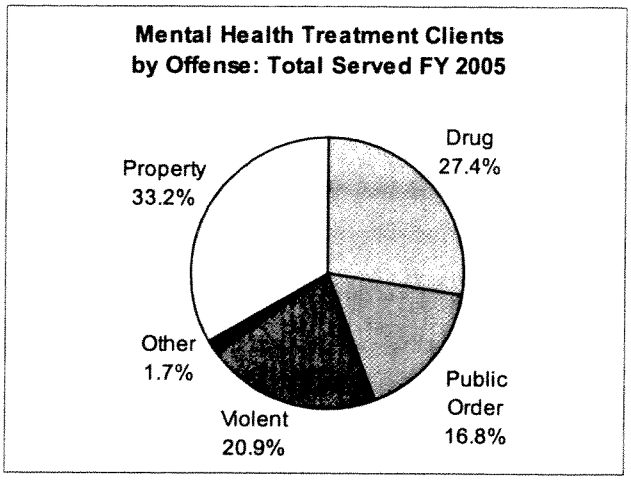
Mental Health Treatment

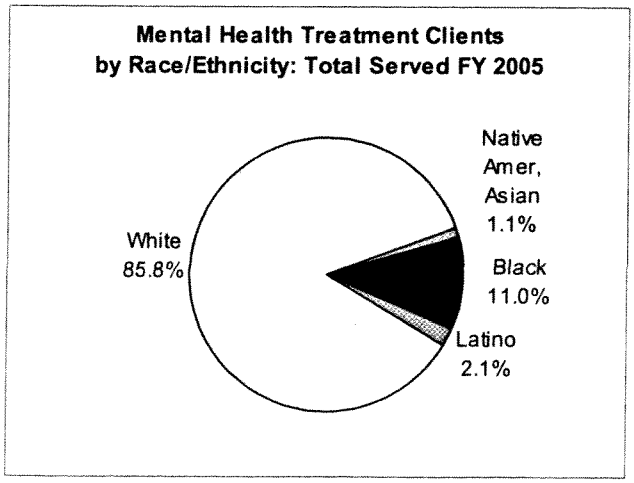
Community-Based Corrections

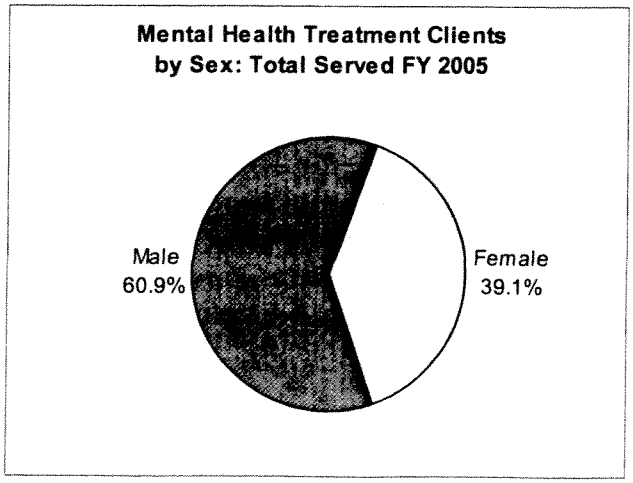
During FY2005, a total of 1,533 offenders under community-based corrections supervision received mental health treatment, usually psychiatric or psychological services. **Please note these are interventions documented on ICON, and likely under-represent the numbers of offenders receiving mental health treatment while under supervision.**

Treatment clients represented a range of offenses, and were mostly Caucasian. A large portion (39.1%) was female.







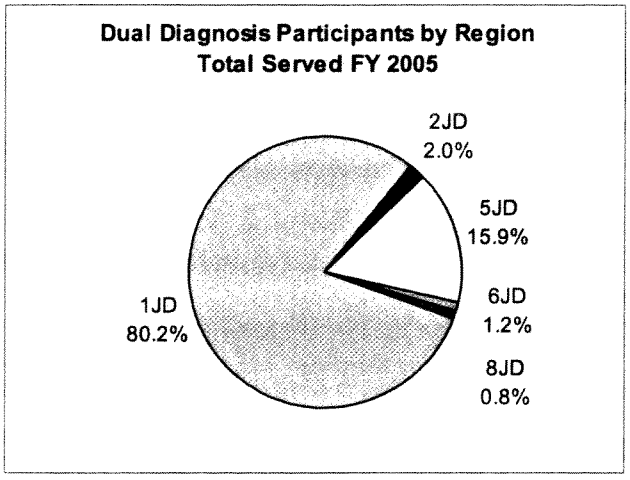


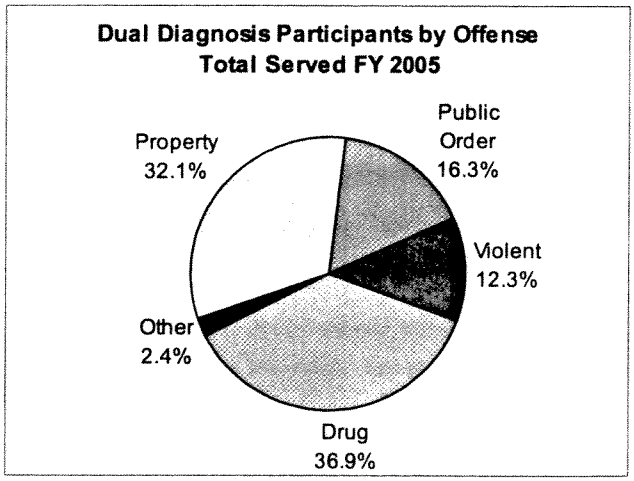
Dual Diagnosis Interventions

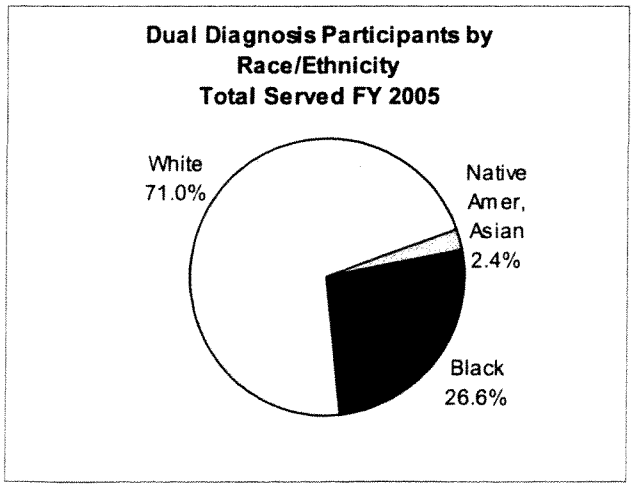
A dual disorder occurs when an individual is affected by both chemical dependency and mental illness. According to a report published by the *Journal of the American Medical Association*:

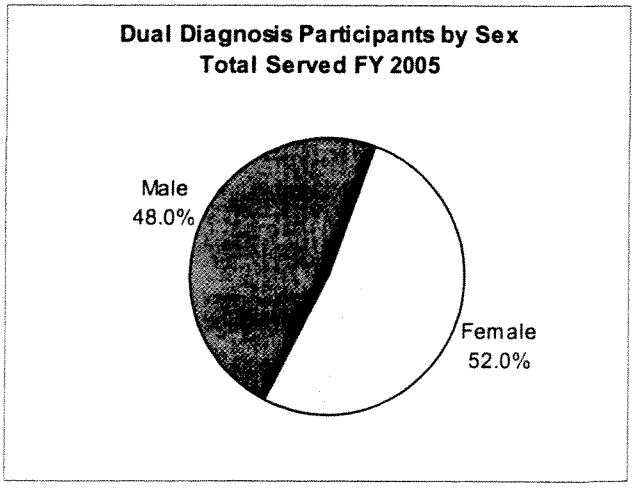
- 37% of alcohol abusers and 53% of drug abusers have at least one serious mental illness.
- Of all people diagnosed as mentally ill, 29% abuse either alcohol or drugs.[5]

Dual diagnosis interventions represent a comprehensive approach to addressing both these issues. During FY2005, a total of 252 offenders under community-based corrections supervision received dual diagnosis interventions, with most participating in the first judicial district's program. Participants represented a range of offenses, and a comparatively large portion was African-American. Female offenders made up the majority of participants.









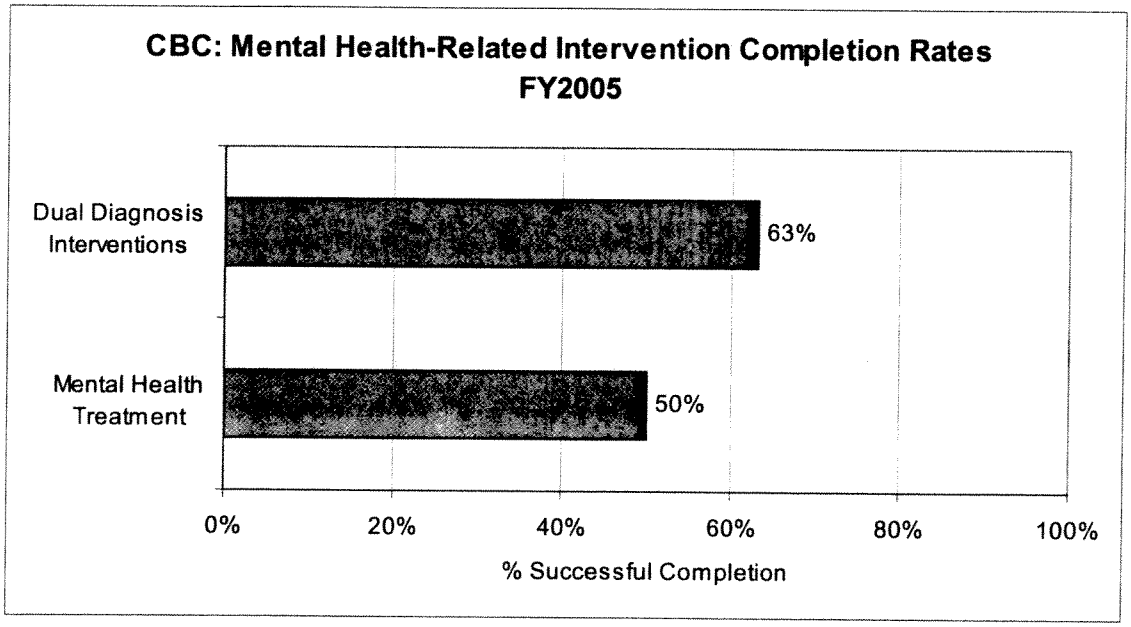
[5] As quoted in National Mental Health Association, *Substance Abuse – Dual Diagnosis* (April 2003) at http://www.nmha.org/infoctr/factsheets/03.cfm.

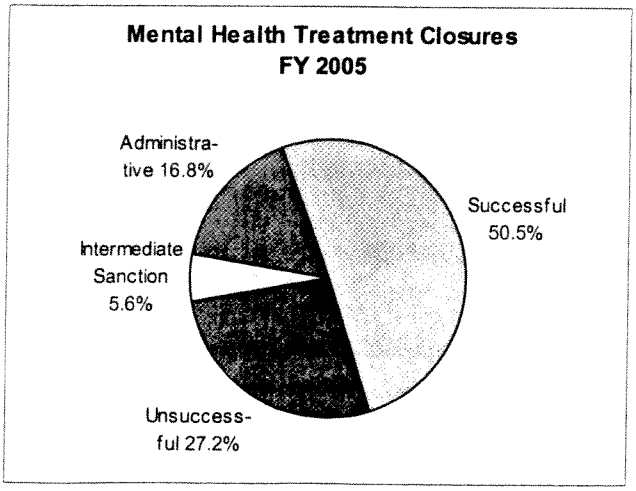
Outcomes: Intervention Completion Rates

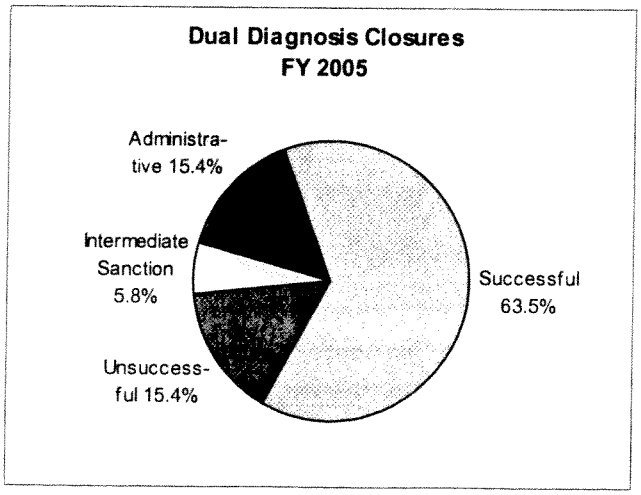
Community-Based Corrections

Treatment providers endeavor to ensure the success of offender participants, including keeping participants in the program wherever possible. Rates of successful completion are one way to assess how well programs are performing their mission. However, other factors such as the risk levels of offenders being served by a particular program also affect completion rates. Because offender risk may vary from program to program, outcome evaluations are an important way to assess whether a particular program is effective.

Rates of successful completion do not mean that the other half were unsuccessfully discharged. Administrative closures (such as transfer to another jurisdiction) and the use of intermediate sanctions to address violating behaviors short of revocation to prison represent other types of closures.







Mental Health Interventions & Treatment

Prisons

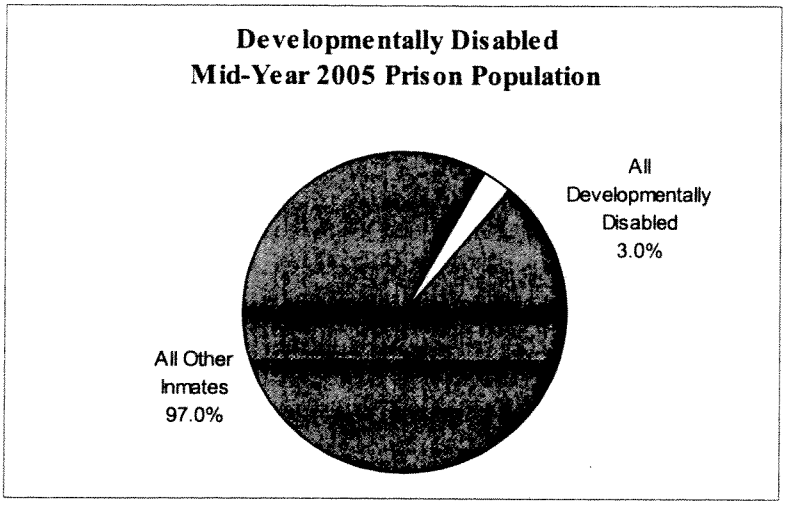
There is limited documentation on ICON describing mental health interventions in institutions. Health Services staff, including psychiatrists and psychologists, have been generally transitioning to the ICON-Medical module to document mental health appointments. Mental health-related appointments in ICON-Medical are mixed with medical appointments, and are not currently readily distinguishable from medical matters. Once this transition is complete, reports will be available from ICON-Medical to describe mental health services provided to institution offenders.

Prison-based interventions for the mentally ill are primarily psychiatric and psychological services, with proper medication where indicated. There is also a special program at the Mt. Pleasant Women's Unit, called STEPPS (Systems Training for Emotional Predictability and Problem-Solving) for offenders with borderline personality disorders.

Under the direction of the Iowa Department of Corrections' new Director of Mental Health, changes will occur to further strengthen the provision of mental health services within the prison system.

Offenders with Developmental Disabilities in Prison

Persons with developmental disabilities may also pose challenges with regard to behavior management, and need for specialized services. On June 30, 2005 Iowa's prisons held 8,578 offenders. Of these, 256 had developmental disabilities per psychiatric diagnosis. **These numbers may under-represent the true number of offenders with developmental disabilities because currently not all inmates receive IQ and development testing.**



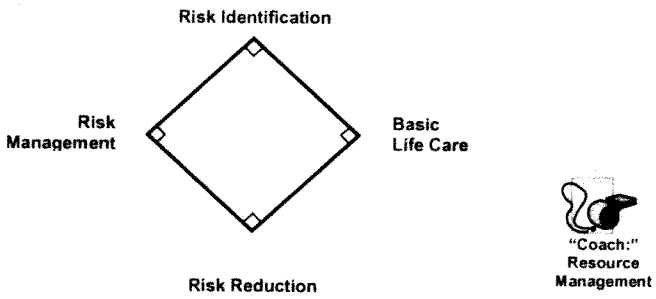
The most common documented developmental disability is attention deficit disorder, with hyperactivity; 203 or about 79% of the 256 offenders in prison who had developmental disabilities had this diagnosis.

Developmental Disabilities		
ICD9 Code	**ICD9 Description**	**N Inmates**
314.01	Attention deficit disorder, w/hyperactivity*	203
V62.89	Borderline intellectual functioning	43
317	Mental retardation, mild	11
315.2	Learning disorder	2
315.8	Development delay, other specified	1
314.00	Attention deficit disorder, non-hyperactive	1

A given offender may have more than one of these diagnoses.
* The Director of Mental Health is currently evaluating the validity of this apparent outlier.

Commitment to Evidence-Based Practices

The corrections system does four fundamental things. The first three, basic life care for offenders, risk identification and risk management, cover the bases of managing offenders. However, only risk reduction "hits a home run" to significantly affect offender outcomes and community safety, and improve the state's return on investment in corrections spending.



The Iowa Department of Corrections is committed to providing mental health interventions to those in need wherever possible, for offenders under community-based supervision and in prison. Mental health care, including the provision of proper medication where indicated, is part of basic life care – so fundamental we cannot get to "first base" without it.

At the same time, we cannot overlook that proper assessment, management and treatment of offenders with mental illnesses and/or developmental disabilities are keys to ensuring successful offender reentry for these individuals. As new mental health programs and protocols are implemented, appropriate outcome studies will be conducted to determine whether or not the program has been successful at achieving risk reduction for offenders.